مرکن

PRINTED: 02/15/2011 FORM APPROVED OMB NO. 0938-0391

NAME OF PROVIDER OR SUPPLIER  COVENTRY MEADOWS  STREET ADDRESS, CITY, STATE, ZIP CO 7843 W JEFFERSON BLVD FORT WAYNE, IN 46804  (X4) ID PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  F 000 INITIAL COMMENTS  A. BUILDING B. WING  STREET ADDRESS, CITY, STATE, ZIP CO 7843 W JEFFERSON BLVD FORT WAYNE, IN 46804  FORT WAYNE, IN 46804  PREFIX (EACH CORRECTIVE ACTION DEFICIENCY)  F 000 INITIAL COMMENTS  F 000	02/0 DE RECTION SHOULD BE	C 4/2011  (X5) COMPLETION DATE
COVENTRY MEADOWS  7843 W JEFFERSON BLVD FORT WAYNE, IN 46804  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE DEFICIENCY)	RECTION SHOULD BE	COMPLETION
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  TAG CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	COMPLETION
F 000 INITIAL COMMENTS F 000		
This visit was for the investigation of complaint #IN00085677 and IN00084774.  Complaint #IN00085677 Substantiated, Federal/State Deficiencies related to the Allegations are cited at F282 and F333.  Complaint #IN00084774 Substantiated, Federal/State Deficiencies related to the Allegations are cited at F282 and F333.  Survey Dates: February 3, 4, 2011  Facility Number: 004945 Provider Number: 155756 AIM Number: 200814400  Survey Team: Julie Wagoner, RN TC Tim Long, RN Angie Strass, RN  Census Bed Type: SNF: 37	ı	
SNF/NF: 107 TOTAL: 144  Census Payor Type: Medicare: 40 Medicaid: 72 Other: 32 Total: 144  Sample: 09 These Deficiencies also reflect state findings in accordance with 410 IAC 16.2.  LABORATORY DIRECTOR'S OF PROVIDE RISUPPLIER REPRESENTATIVE'S SIGNATURE  TITLE		(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		155756	B. WING_		C 02/04/2011
	ROVIDER OR SUPPLIER		;	REET ADDRESS, CITY, STATE, ZIP CODE 7843 W JEFFERSON BLVD FORT WAYNE, IN 46804	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOT CROSS-REFERENCED TO THE APPLICATION OF THE APPLICATI	OULD BE COMPLETION
F 282 SS=G	Quality review com Cathy Emswiller RI 483.20(k)(3)(ii) SEI PERSONS/PER C.  The services proviem ust be provided by accordance with eacare.  This REQUIREME by: Based on record refailed to follow physafter being discharresidents (B, D, an reviewed. Two of treadmitted to the home including but not lir Congestive Heart For Coronary Artery Dimedication Orders 11/30/10, and lister Home Medications indicated the reside diuretic medication systolic blood prestive "Handwritten Phospital dated 11/3	pleted 2-9-11 N RVICES BY QUALIFIED ARE PLAN  ded or arranged by the facility by qualified persons in ach resident's written plan of  NT is not met as evidenced eview and interview the facility sician orders for medications ged from the hospital for 3 d F) in a sample of 9 records he three residents were ospital. (Resident B and D)  80 p.m. review of the clinical (F) indicated she was ility on 11/30/10 with diagnoses nited to Left Hip Nailing, Failure, Hypertension, and	F 282	The creation and submission of to	ean y hent of of sts that the idered the d requests r rsons/Per to provide plan of be nts found eficient as been re- mission orders sidents cted by d what ission or i the



			(X3) DATE S COMPLE			
		155756	B. WIN			C 4/2011
NAME OF P	ROVIDER OR SUPPLIER	100/00		STREET ADDRESS, CITY, STATE, ZIF		4/2011
COVENT	RY MEADOWS			7843 W JEFFERSON BLVD FORT WAYNE, IN 46804		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG		TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 282	The Medication Adi December indicate Lasix 40 milligrams 12/4/2010. Nursing p.m. indicated "2+ pankle 1+ non pittin ankle. Alert and or known. Breath soubreath noted. Nursing received and noted Wednesday 12/8/1 potassium 20 miller in the AM (morning and daughter notified. A progress note wr "Nursing concern with eweekend (yest call notified of pulm per chest x-ray) Latand KCL (potassium A physicians teleph practitioner for the indicated "Give lasi daily - extra tab tod milligrams. Decrea 3.125 milligrams per nasal cannula (continuous. Chest Friday. Lab today today."  Nursing notes date indicated "Resident breath and was continuous continuous."	ministration Record for d the resident did not receive daily on 12/1, 12/2, 12/3 and g notes dated 12/5/10 at 12:00 bitting edema (swelling) to left g edema to right foot and iented able to make needs inds clear no shortness of se Practitioner called new order chem 6 (laboratory test) on 0 Lasix 40 milligrams daily quivelents daily. Ted hose on ) and off at HS (bedtime) Labed."  itten 12/6/10 indicated with coarse breath sounds over erday) nurse practitioner on ionary congestion (diagnosis six 40 milligrams every day m) 20 millequivalents daily.  In one order - (per nurse cardiologist) dated 12/7/10 x @ 40 milligrams per mouth ay & tomorrow for 80 ase Coreg (heart medication) to be mouth twice daily. Oxygen @ 2 liters per minute x-ray Friday. Return to clinic BMP -BNP completed in office daily. Said she	F 2	affected by the alleg practice.  Licensed Nurses will in transcribing admis admission physician Staff Development C designee by 03-06-1  What measures will be what systemic changes ensure that the deficien not recur  Licensed Nurses will in transcribing admi admission physician Staff Development C (SDC) or designee be Admission and re-ac physician orders will two licensed nurses admission or re-adm physician orders are accurately.  Admission and re-ac will be reviewed in by using the IDT Ac admission Review T Friday (excluding he Management to ensure the practice will not recur, assurance program will place	l be re-educated ssion and re-orders by the Coordinator or 1.  put into place or you will make to t practice does  l be re-educated ssion and re-orders by the Coordinator by 03-06-11. It is is in the ensure transcribed dimission to ensure transcribed dimission/Re-Tool Monday-olidays) by Nurse are physician ed accurately.  ion(s) will be e deficient i.e., what quality	
		mperature 99.8 pulse 78 od pressure 120/70. Oxygen		place.		



	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION (X A. BUILDING		(X3) DATE SURVEY COMPLETED		
		155756	B. WIN	G		02/04	) 1/2011
	ROVIDER OR SUPPLIER			78	EET ADDRESS, CITY, STATE, ZIP CODE 343 W JEFFERSON BLVD ORT WAYNE, IN 46804		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 282	saturation fluctuating called, new orders aroom for evaluation called to emergency and transported reside hospital with diagnot Recent hip surgery  2. The clinical recorreviewed on 02/03/was admitted to the facility, on 01/25/11 not limited to, carding miocardial infarction renal function, and  The admission physical form the acute care the following medic Calcium Carbonate Colace (a stool soft blood pressure medication and pressure and to import the heart after a Sulfate 325 mg (and midiabetic medication), Metfor antidiabetic medication, Metfor antidiabetic medication and relieve chest pressure and to import the heart after a sublingual (a medication), Metfor antidiabetic medication and relieve chest pressure and to import the medication and pressure and to import the heart after a sulfate 325 mg (and pain, Lasix 80 medication), Metfor antidiabetic medication and relieve chest pressure and to import the medication and pressure and to import the heart after a sulfate 325 mg (and pain, Lasix 80 medication), Metfor antidiabetic medication and relieve chest pressure and to import the medication and pressure	and between 88-90%. Doctor received to sent to emergency and Daughter here. Report by room. Paramedics called sident to emergency room."  In Report dated 12/9/10 and was admitted to the poses of Pneumonia, Dyspnea, and Anemia.  In at 2:00 P.M. The resident at 2:00 P.M. The resident are facility, from an acute care with diagnosis, including but comyopathy, history of an diabetes mellitus, impaired mitral valve issues.  In a sician orders, faxed and sent are facility, included orders for ations: "Aspirin 81 mg daily, at 600 mg three times a day, tener) 100 mg daily, Coreg (a dication given for high blood prove the left ventricular action myocardial infarction), Ferrous iron supplement), Imdur 90 medication to improve the lood vessel constriction	F 2	.82	<ul> <li>An Admission/Readmission         Procedure CQI tool will be u         weekly x 4 then monthly the</li> <li>Data will be submitted to the         committee for review and for         Non-compliance may result         disciplinary action up to and         termination.</li> <li>The Director of Nursing Serv         (DNS) and or designee will be         responsible for program common compliance date: 03-06-11</li> </ul>	reafter. c CQI llow-up. in including vices	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		155756	B. WIN	IG		1	C <u>4/<b>2011</b></u>
	ROVIDER OR SUPPLIER	•		784	ET ADDRESS, CITY, STATE, ZIP CODE 3 W JEFFERSON BLVD RT WAYNE, IN 46804		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
F 282	antidepressant), Le medication to treat 40 mg at bedtime (a cholesterol)" The a form listed some of "Active Reported H medications, includ medications listed ulist, under the title "Both sections had "marked for each ind Active Home Medica black pen line draorders.	vothyroxine 200 mcg daily (a thyroid disorders), Simvastatin a medication to treat high acute care center discharge the medication orders under a ome Medication" list and some ing some but not all of the under the home medication Active Inpatient Medications." Continue or Discontinue dividual medication listed. The eations section of the form had own horizontally through the	F2	282			
	orders for Resident Administration Recomedications listed a were transcribed or following medication administered to Residaily, Synthroid 200 mg daily, Simvastat Carb with Vitamin E Aspirin 81 mg once mg as needed daily sublingual every 5 richest pain. The resident residen	the admission medication D, including the Medication ord, indicated only those as Active Inpatient Medication nto the form. Thus only the ns were transcribed and sident D: Citalopram 40 mg mcg daily, Omeprazole 20 in 40 mg at bedtime, Calcium 0 600 mg three times a day, a day, Docusate Sodium 100 i, and Nitrostat .4 mg ininutes times 3 as needed for sident did not receive the turosemide, Ferrous Sulfate,					
	02/03/11 at 1:45 P.I care facility automa Medication List ordedischarge form from indicated if the physical care of the physical care o	irector of Nursing, on M. indicated the long term tically disregarded the Home ers section from the 6 pages in the acute care facility. She sician desired to have any ther than those the resident				·	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION	(X3) DATE SU COMPLE	
		155756	B. WING _		C 02/04/2011	
	ROVIDER OR SUPPLIER		7	REET ADDRESS, CITY, STATE, ZIP CODE 843 W JEFFERSON BLVD FORT WAYNE, IN 46804		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 282	the medication in a was no specific time acute care facility to disrefrom the Home Med Director of Nursing discharge orders from facility started about facility started disrefroder list, the need greatly reduced. So facility had in the pathe orders because shifts and/or the choon the nursing floor	ent, there was a space to write the end of the form. There is frame or person from the nat had directed the long term gard the medication orders dications list orders. The indicated the issues with the om this specific acute care to 2 years ago and since the garding the Home Medication for clarification had been the indicated the long term care ast had trouble trying to clarify the floor nurse's changed art was not always available after the resident was ong term care facility.	F 282			
	Administrative Direct 9:15 A.M. and phone Coordinator, on 02/no one at the acute instructed the long to the medication order list. The Nursing Administered after the long term care of the long term	cute care center's Nursing ctor of Nursing, on 02/04/11 at the interview with the Discharge 04/11 at 9:15 A.M. indicated care center had ever term care facilities to disregard ers in the Home Medication dministrative Director of the discharging physician the six page form and tions marked "Continue" to be the resident was discharged to acilities or to their respective evaluations were and sometimes marked the ith two different strengths or the same medication class scharging nurse from the id not "catch" the error and the ins, then the long term care to "clarify" the orders. She				

	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X3) DATE SURVEY COMPLETED			
		155756	B. Wil	ив <u>—</u>		02/	C 04/2011
İ	PROVIDER OR SUPPLIER			78	EET ADDRESS, CITY, STATE, ZIP C 43 W JEFFERSON BLVD DRT WAYNE, IN 46804		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
	indicated there was around the clock in office of the acute of electronic record who care facility with class medication orders. Medication orders from the physicacute care center endicate order or the physicacute care center endicate order orders for the panoted to be having ordered	always a nurse working the administrative nursing the administrative nursing tare center with access to the no could assist the long term rifying any questionable. Review of the discharge or Resident D, written and targing physician, on 01/25/11, no line drawn across the st orders.  In g progress notes, dated and indicated the resident had eath, developed cool, clammy sugar of 258, oxygen to 89 - 94 percent on oxygen, aves, and blood pressure, pulse elevated at 100 beats sident was transferred to the mergency room.  In a ssessment from the mergency room, dated indicated the resident was tongestive heart failure due to be of her cardiomyopathy ast 3 days. The resident was thest pain and discomfort in the chest x-ray, obtained in The chest x-ray, obtained in A.M. indicated the	F	282			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M		IPLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED	
	•	155756	B. WIN	IG _			C <b>4/2011</b>
	ROVIDER OR SUPPLIER			7	REET ADDRESS, CITY, STATE, ZIP CODE 7843 W JEFFERSON BLVD FORT WAYNE, IN 46804		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 282	,		F2	282	·		
·	2/4/11 at 10:00 A.M resident was origina 12/23/10 for rehabil knee amputation (A 1/24/11 through 1/2	cal record was reviewed on  The record indicated the ally admitted to the facility on itation following an above the KA) of her right leg. On 8/11 she was in an acute on of the right AKA and cility on 1/28/11.		-			
	from the hospital on groupings of medica	d discharge physician's orders 1/28/11 indicated 2 separate ations: "Active Reported Home rified 1/27/2011 05:56" and dications".					
	Aspirin EC 81 mg (r Coumadin 3 mg ora Wednesday and Fridaily on Tuesday, Tl Sunday. The active included Aspirin EC	home medications included nilligrams) oral daily and I daily on Monday, days and Coumadin 2.5 mg hursday, Saturday and inpatient medications 81 mg oral daily. The active s did not include Coumadin.					
	record) for January 2 from the hospital on ordered Aspirin 81 n daily, orally at 10:00 Aspirin EC 81 mg wa 1/29/11, 1/30/11 and	(medication administration 2011 indicated upon return 1/28/11, the physician ng was written to be given P.M The MAR indicated the as not given on 1/28/11, 1/31/11. The Physician was not written on the MAR.					
	indicated the Aspirir to pre-hospitalization on Coumadin but no	e DN on 2/4/11 at 10:45 A.M. n 81 mg was not started due n on 1/24/11 the resident was t Aspirin. The DN indicated r ordered a lab test, a					

	F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUI		G	COMPLET	TED
		155756	B. WIN	IG_		02/04	/ //2011
	ROVIDER OR SUPPLIER			78	EET ADDRESS, CITY, STATE, ZIP CODE 843 W JEFFERSON BLVD ORT WAYNE, IN 46804		
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F 282	PT-INR on 1/29/11 anemia. The DN st to not give Aspirin or results were completed. The PT-INR results and the Nurse Practice new orders were rephysician ordered were written for the was started on 2/1/	due to Coumadin therapy and ated she assumed that meant or Coumadin until the PT-INR eted.  s were completed on 1/29/11 ctitioner was notified and no eccived. On 1/31/11 the 'no Coumadin'. No new orders e Aspirin. Aspirin EC 81 mg 111.	F2	282			
F 333 SS=G		DENTS FREE OF D ERRORS nsure that residents are free of	F:	333	F333 Residents free of significa errors It is the practice of this provider that residents are free of any sign medication errors.	to ensure	
	by: Based on record refailed to ensure signot made and medordered for 3 residents of 9 records review.	NT is not met as evidenced eview and interview the facility inificant medication errors were lications were administered as ents (B, D, and F) in a sample yed. Two of the three residents the hospital. (Resident B and			<ul> <li>What corrective action(s) will I accomplished for those residen to have been affected by the depractice.</li> <li>Licensed nursing staff has be education on transcribing ad and re-admission physician to administer medications as by the physician.</li> <li>How will you identify other resident</li> </ul>	ts found ficient  een re- mission orders and s ordered	
	record for resident admitted to the fac	30 p.m., review of the clinical (F) indicated she was ility on 11/30/10 with diagnoses nited to Left Hip Nailing,			having the potential to be affect the same deficient practice and corrective action will be taken	eted by I what	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING				(X3) DATE SURVEY COMPLETED	
		155756	B. Wit	NG			C 94/2011	
	PROVIDER OR SUPPLIER			78	EET ADDRESS, CITY, STATE, ZIP CODE 43 W JEFFERSON BLVD DRT WAYNE, IN 46804			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	DULD BE	(X5) COMPLETION DATE	
F 333	Congestive Heart F Coronary Artery Dis The Medication Ord 11/30/10, and listed Home Medications- indicated the reside diuretic medication) systolic blood press the "Handwritten Pr hospital dated 11/30 Meds, Parameter for pressure."  Review of the Medic for December indicareceive Lasix 40 mil 12/02/10, 12/03/10, dated 12/5/10 at 12 edema (swelling) to edema to right foot a able to make needs no shortness of brea called new order red (laboratory test) on milligrams daily pote daily. Ted hose on it HS (bedtime) Lab a A progress note writ "Nursing concern with weekend (yeste call notified of pulmo per chest x-ray) Las and KCL (potassium  A physicians telepho practitioner for the call	ailure, Hypertension, and	F	333	<ul> <li>Residents requiring an admireadmission to facility from hospital have the potential to affected by the alleged defice practice.</li> <li>Licensed Nurses will be redin transcribing admission/readmission physician orders administer medications as of the physician by the Staff Development Coordinator (edesignee by 03-06-11.</li> <li>What measures will be put into what systemic changes you will ensure that the deficient practinot recur</li> <li>Licensed Nurses will be redin transcribing admission and admission physician orders administer medication as or the physician by the Staff Development Coordinator (edesignee by 03-06-11.</li> <li>Admission and re-admission physician orders will be reviewed in urses upon the admission or re-admission to physician orders are transcriaccurately.</li> <li>Admission and re-admission will be reviewed in morning using the IDT Admission/Readmission Review Tool Mo Friday (excluding holidays)</li> </ul>	the o be sient educated e- and to rdered by SDC) or make to ice does educated ad re- and to dered by SDC) or in iewed by e o ensure ibed in orders g meeting e- nday-		



	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		IPLE CONSTRUCTION	(X3) DATE SU COMPLE	
		155756	B. WIN	IG_		1	C 4/2011
	ROVIDER OR SUPPLIER		<b>1</b>	7	REET ADDRESS, CITY, STATE, ZIP CODE 843 W JEFFERSON BLVD FORT WAYNE, IN 46804	, 72.0	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 333	daily - extra tab tod milligrams. Decrea 3.125 milligrams pe per nasal cannula ( continuous. Chest Friday. Lab today today."  Nursing notes date indicated "Resident breath and was cou	ay & tomorrow for 80 use Coreg (heart medication) to be mouth twice daily. Oxygen 2 liters per minute x-ray Friday. Return to clinic BMP -BNP completed in office d 12/9/10 at 9:30 p.m. complaining of shortness of lighing frequently. Said she	F 3	333	Management to ensure physicorders are transcribed accura  How the corrective action(s) will monitored to ensure the deficie practice will not recur, i.e., what assurance program will be put place  • A Medication Errors CQI to	ill be nt at quality into	
	didn't feel well. Ter respirations 23 bloc saturation fluctuatin called, new orders room for evaluation called to emergence and transported resummers. The Emergency Roundicated the reside	Inperature 99.8 pulse 78 od pressure 120/70. Oxygen og between 88-90%. Doctor received to sent to emergency of Daughter here. Report of room. Paramedics called dident to emergency room."  In the composition of the composit	,		utilized weekly x 4 then more thereafter.  Data will be submitted to the committee for review and for Non-compliance may result disciplinary action up to and termination.  The Director of Nursing Ser (DNS) and or designee will responsible for program common Compliance date: 03-06-11.	e CQI llow-up. in including vices be	
	reviewed on 02/03/ was admitted to the facility, on 01/25/11 not limited to, cardio miocardial infarction renal function, and						
	from the acute care the following medica Calcium Carbonate Colace (a stool soft blood pressure medical	sician orders, faxed and sent facility, included orders for ations: "Aspirin 81 mg daily, 600 mg three times a day, ener) 100 mg daily, Coreg (a lication given for high blood prove the left ventricular action					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M A. BUII		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
-		155756	B. WIN	G		i	C <b>4/2011</b>
	PROVIDER OR SUPPLIER			7843	FADDRESS, CITY, STATE, ZIP CO W JEFFERSON BLVD T WAYNE, IN 46804		
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F 333	of the heart after a Sulfate 325 mg (an mg daily (a cardiac circulation and prevand pain, Lasix 80 medication), Metfor antidiabetic medica sublingual (a medica sublingual (a medica and relieve chest pausually given as neetab daily (a medica reflux disease), cita antidepressant), Lemedication to treat the 40 mg at bedtime (a cholesterol). The aform listed some of "Active Reported Homedications, including medications listed under the title." Aboth sections had "comarked for each index a black pen line dray orders.	myocardial infarction), Ferrous iron supplement), Imdur 90 medication to improve ent blood vessel constriction	F3	33			
	orders for Resident Administration Reco medications listed a were transcribed on following medication administered to Res daily, Synthroid 200 mg daily, Simvastati Carb with Vitamin D	D, including the Medication rd, indicated only those is Active Inpatient Medication to the form. Thus only the is were transcribed and ident D: Citalopram 40 mg mcg daily, Omeprazole 20 in 40 mg at bedtime, Calcium 600 mg three times a day, a day, Docusate Sodium 100					

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		155756	B. WING			1	C 2/04/2011	
NAME OF PROVIDER OR SUPPLIER  COVENTRY MEADOWS				7	REET ADDRESS, CITY, STATE, ZIP CODE 843 W JEFFERSON BLVD FORT WAYNE, IN 46804			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
F 333	sublingual every 5 r chest pain. The res Metformin, Imdur, F or the Coreg.	minutes times 3 as needed for sident did not receive the Furosemide, Ferrous Sulfate, pirector of Nursing, on	F	333				
	02/03/11 at 1:45 P. care facility automa Medication List ordedischarge form from indicated if the physother medications chad received inpatie the medication in at was no specific time acute care facility to disrefrom the Home Medication in the medication in at was no specific time acute care facility to disrefrom the Home Medication in the Ho	M. indicated the long term tically disregarded the Home ers section from the 6 pages in the acute care facility. She sician desired to have any other than those the resident ent, there was a space to write the end of the form. There is frame or person from the nat had directed the long term gard the medication orders dications list orders. The						
	Director of Nursing indicated the issues with the discharge orders from this specific acute care facility started about 2 years ago and since the facility started disregarding the Home Medication order list, the need for clarification had been greatly reduced. She indicated the long term care facility had in the past had trouble trying to clarify the orders because the floor nurse's changed shifts and/or the chart was not always available on the nursing floor after the resident was discharged to the long term care facility.							
	Administrative Direct 9:15 A.M. and phon Coordinator, on 02/0 no one at the acute instructed the long to the medication order list. The Nursing Administrative Director 10:15.	cute care center's Nursing ctor of Nursing, on 02/04/11 at e interview with the Discharge 04/11 at 9:15 A.M. indicated care center had ever erm care facilities to disregard rs in the Home Medication dministrative Director of e discharging physician						

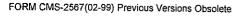
AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED		
155756			B. WIN	1G _		C 02/04/2011		
NAME OF PROVIDER OR SUPPLIER  COVENTRY MEADOWS				7	REET ADDRESS, CITY, STATE, ZIP CODE 7843 W JEFFERSON BLVD FORT WAYNE, IN 46804	1 0210	772011	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			IX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 333	personally marked intended all medica administered after the long term care thomes. She acknotoccasionally sloppy same medication with two medications from the care facility declarify the medication facility would need to indicated there was around the clock in office of the acute of	the six page form and tions marked "Continue" to be the resident was discharged to acilities or to their respective wledged the physicians were and sometimes marked the ith two different strengths or m the same medication class scharging nurse from the id not "catch" the error and ons, then the long term care to "clarify" the orders. She always a nurse working the administrative nursing are center with access to the	F	333				
	care facility with cla medication orders. medication orders f signed by the dischi indicated there was Home Medication list Review of the nursi	no could assist the long term rifying any questionable Review of the discharge or Resident D, written and arging physician, on 01/25/11, no line drawn across the st orders.  In progress notes, dated .M. indicated the resident had						
-	become short of bre skin, elevated blood saturation dropped resident had dry hea elevated to 181/100	eath, developed cool, clammy sugar of 258, oxygen to 89 - 94 percent on oxygen, aves, and blood pressure , pulse elevated at 100 beats sident was transferred to the						
	center emergency re A.M. indicated the re congestive heart fail number of her cardi	ssment from the acute care com, dated 01/28/11 at 12:06 esident was assessed to be in ure due to not receiving a comyopathy medicines for the sident was noted to be having						



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		IPLE CONSTRUCTION  IG	COMPLETED	
155756		B, WIN	√G _		C 02/04/2011		
NAME OF PROVIDER OR SUPPLIER  COVENTRY MEADOWS				7	REET ADDRESS, CITY, STATE, ZIP CODE 1843 W JEFFERSON BLVD FORT WAYNE, IN 46804		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 333	The chest x-ray, ob A.M. indicated the increase in congest from 01/22/11 with pleural fluid. The ronoted to be elevate the acute care cent 3. Resident B's clin 2/4/11 at 10:00 A.M resident was origina 12/23/10 for rehabi knee amputation (A1/24/11 through 1/2 hospital for a revision readmitted to the father than the signed dischart hospital on 1/28/11 groupings of medications-last Ve "Active Inpatient Medication and The active reported Aspirin EC 81 mg (Coumadin 3 mg ora Wednesday and Fridaily on Tuesday, Tounday. The active reported as the signed dischart for the active reported Aspirin EC 81 mg (Coumadin 3 mg ora Wednesday and Fridaily on Tuesday, Tounday. The active	comfort in the emergency room stained on 01/28/11 at 12:05 resident's Xray suggested an tive heart failure, increased lung interstitial edema and esident's blood sugar was also d when she was admitted to ter.  ical record was reviewed on 1. The record indicated the ally admitted to the facility on litation following an above the AKA) of her right leg. On 28/11 she was in an acute on of the right AKA and acility on 1/28/11.  Ige physician's orders from the indicated 2 separate ations: "Active Reported Home erified 1/27/2011 05:56" and edications".	F	333			
	The MAR (medicated January 2011 indicated hospital on 1/28/11 81 mg was written 10:00 P.M The Market 10:00 P.M The P.M. T	ns did not include Coumadin. ion administration record) for ated upon return from the , the physician ordered Aspirin to be given daily, orally at AR indicated the Aspirin EC 81 on 1/28/11, 1/29/11, 1/30/11					

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AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
155756			B. WII	VG			C <b>02/04/2011</b>		
	ROVIDER OR SUPPLIER			78	ET ADDRESS, CITY, ST 43 W JEFFERSON BL DRT WAYNE, IN 46	VD			
(X4) ID PREFIX TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)			PROVIDER'S PLAN OF CORRECT IX (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)			ULDBE	(X5) COMPLETION DATE	
ŀ	An interview with the indicated the Aspirit to pre-hospitalization on Coumadin but not the nurse practitione PT-INR on 1/29/11 anemia. The DN state to not give Aspirin or results were completed by the PT-INR results and the Nurse Practinew orders were reciphysician ordered "rwere written for the present t	hysician ordered Coumadin he MAR.  e DN on 2/4/11 at 10:45 A.M. n 81 mg was not started due n on 1/24/11 the resident was of Aspirin. The DN indicated er ordered a lab test, a due to Coumadin therapy and sted she assumed that meant r Coumadin until the PT-INR sted.  were completed on 1/29/11 itioner was notified and no seived. On 1/31/11 the to Coumadin". No new orders Aspirin. Aspirin EC 81 mg	F	333					
	was started on 2/1/1 This federal tag rela: #IN00085677						, ,		
	3.1-25(b)(9) 3.1-48(c)(2)								
			·				-		
			-						



Event ID: 1SQN11

Facility ID: 004945

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